

KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES COVID-19 GUIDANCE

DATE: March 15, 2021 (*updated October 29, 2021*)

TO: State & Local Officials, Adult Care Home Operators/Owners/Administrators, Stakeholders, Industry Associations, General Public

FROM: Secretary Laura Howard

SUBJECT: Visitation Guidance for Long Term Care Settings

EFFECTIVE: Immediately

The Centers for Medicare and Medicaid Services (CMS) updated its September 17, 2020 guidance ([QSO-20-39-NH](#)) regarding visitation in nursing homes. KDADS recognizes other long-term care settings in Kansas are not subject to the guidance issued by CMS for certified nursing facilities. Using the guidance of CMS, Center for Disease Control and Prevention (CDC) and Kansas Department of Health and Environment (KDHE); KDADS updated its visitation guidelines for all long-term care settings in Kansas including Assisted Living, Board Care Home, Home Plus, Nursing Facility and Residential Health Care Facilities.

KDADS recognizes the prolonged separation of long-term care residents from their loved ones has taken a significant toll on the health of everyone involved; as well as the need to continue to protect this vulnerable population. Visitation is a right for residents in adult care homes and facilities should make best efforts to facilitate visitation for residents and their loved ones or preferred visitors.

Acknowledging that many residents and staff of adult care homes have been vaccinated, the updated guidance on visitation promotes connecting residents and their loved ones. The guidance also continues to emphasize the importance of strong infection control practices, testing for the presence of the COVID-19 virus, and effective responses to outbreaks of COVID-19 in adult care homes. The vaccine provides an additional level of protection from COVID-19 infection but must be balanced with maintaining and practicing the core principles of infection control that have been in place throughout the pandemic.

Regardless of how visits are conducted, there are certain [core principles and best practices](#) that reduce the risk of COVID-19 transmission:

Core Principles of COVID-19 Infection Prevention

- Screening of all who enter the facility for signs and symptoms of COVID-19 (e.g., temperature checks, questions about and observations of signs or symptoms), and denial of entry of those with signs or symptoms or those who have had close contact with someone with COVID-19 infection in the prior 14 days regardless of the visitors vaccination status.
- Appropriate [hand hygiene](#) (use of alcohol-based hand rub is preferred).
- Face covering or mask (covering mouth and nose) in accordance with [CDC guidance](#).
- Social distancing of at least six feet between persons.
- The facility must have Instructional signage throughout the facility and proper visitor education on COVID-19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of face coverings or masks, specified entries, exits and routes to designated areas, hand hygiene).
- Cleaning and disinfecting high frequency touched surfaces in the facility often, and designated visitation areas after each visit.
- Appropriate staff use of Personal Protective Equipment (PPE).
- Effective cohorting of residents when COVID-19 infections are identified (e.g., separate areas dedicated to COVID-19 care).

These core principles are consistent with the CDC guidance for [nursing homes](#) and [assisted living](#) and should be adhered to at all times.

Visitation should be person-centered, consider the residents' physical, mental, and psychosocial well-being, and support their quality of life. Facilities should enable visits to be conducted with an adequate degree of privacy. Visitors who are unable to adhere to the core principles of COVID-19 infection prevention should not be permitted to visit or should be asked to leave. By following a person-centered approach and adhering to these core principles, visitation can occur safely based on the guidance below.

To ensure resident rights are not violated and that visitation plans are person-centered and able to be executed by the resident, facility and visitor, KDADS has created the [Resident Visitation Preferences Template](#) to identify the types of questions and issues that should be discussed to facilitate visitation. All long-term care facilities should utilize the template found at the end of this guidance or a form of their own that captures the same information showing that a discussion has been held between a staff member and resident, resident's representative or resident's family. The conversations should be made in conjunction with the facility and resident or resident's representative. The conversation should be informed by the facilities capacity to conduct different visitation options. This information should be completed for each resident (as of 01/31/2021) and updated regularly.

It is important facility owners or operators communicate their current status for visitation based on risk factors present within the facility and surrounding community to residents and their friends and family

members who would be affected by visitation restrictions. Families and residents should have a clear understanding of the facility's ability to allow visitation and the conditions when visitation can occur.

Compassionate Care Visits

While end-of-life situations have been used as examples of compassionate care situations, the term “compassionate care situations” does not exclusively refer to end-of-life situations. Examples of other types of compassionate care situations include, but are not limited to:

- A resident, who was living with their family before recently being admitted to a nursing home, is struggling with the change in environment and lack of physical family support.
- A resident who is grieving after a friend or family member recently passed away.
- A resident who needs cueing and encouragement with eating or drinking, previously provided by family and/or caregiver(s), is experiencing weight loss or dehydration.
- A resident, who used to talk and interact with others, is experiencing emotional distress, seldom speaking, or crying more frequently (when the resident had rarely cried in the past).

Allowing a visit in these situations or similar circumstances is consistent with the intent of “compassionate care situations.” Also, in addition to family members, compassionate care visits can be conducted by any individual that can meet the resident's needs, such as clergy or lay persons offering religious and spiritual support. Furthermore, the above list is not an exhaustive list as there may be other compassionate care situations not included. Knowing that many residents and staff of adult care homes have been vaccinated, and the updated CMS guidance for nursing facilities, KDADS is updating our guidance to support connecting residents and their loved ones.

At all times, visits should be conducted using social distancing. However, if during a compassionate care visit a visitor and facility identify a way to allow for personal contact, it should only be done following all appropriate infection prevention guidelines and for a limited amount of time. If the resident is fully vaccinated*, they can choose to have close contact (including touch) with their visitor while wearing a well-fitting face mask and performing hand-hygiene before and after. Regardless, visitors should physically distance from other residents and staff in the facility. Through a person-centered approach, facilities should work with residents, families, caregivers, resident representatives, and the Ombudsman program to identify the need for compassionate care visits. The need for compassionate care visits should be clearly documented in the residents' plan of care or service agreement.

Essential Care Giver

Family members and other close, outside caregivers have a critical role in the care and support of residents, including advocating for their health and well-being. It is strongly recommended Adult Care Homes (ACH) develop a process to designate essential caregivers (EC).

An Essential Caregiver is an individual, including clergy members, who has been given consent by the resident, or their

guardian or legal representative, to provide health care services or assistance with activities of daily living to help maintain or improve the quality of care or quality of life of a facility resident as well as positively influencing the behavior of the resident. Care or services provided by the Essential Caregiver must be included in the plan of care or service plan for the resident and may include assistance with bathing, dressing, eating, and/or emotional support.

ACH's are not required to implement an EC program, but this guidance provides recommendations for facilities that choose to. The goal of designating ECs is to help ensure high-risk residents continue to receive individualized, person-centered care. KDADS will consider essential caregiver visits as a type of compassionate care visit. While not required, KDADS encourages facilities in counties with medium or high levels of community transmission to test visitors, if possible. If so, facilities should prioritize visitors that visit regularly (e.g., weekly). Facilities may also encourage visitors to test on their own. The guidance below provides guidelines and suggestions for the implementation of an EC program in an ACH.

- Facilities must establish policies and procedures for designating a resident's essential care giver and how EC's can be included in a resident's activities.*
- Residents, guardians or legal representatives should consult the facility's Administrator, Director of Nursing, Social Services Director, or other designated facility staff to help determine who meets the criteria of an EC.*
- Residents may want to designate more than one EC, based on their past involvement and needs (e.g., more than one family member previously split time to provide care for the resident). In these unique situations, facility staff should work cooperatively with the resident and family to create a schedule to accommodate the ECs.*
- Only one (1) Essential Caregiver should be present at any given time.*
- EC's should complete facility-designated infection prevention and control training, including proper PPE and mask use, hand hygiene, and social distancing.*
- Facilities should have EC's sign a consent form acknowledging completion of the facility-designated infection prevention and control training, an understanding of the facility's visitation and infection prevention and control policies, and the risk created by frequency and duration of close contact.*
- Consider having EC's complete the temporary nurse aid training program provided by AHCA/NCAL.*
- Consider hanging posters throughout the facility that demonstrate key instructions to reinforce safe practices for infection control and proper PPE usage.*
- EC's should be screened upon arrival and only be allowed entry if the screening criteria are met. A screening criteria should determine whether the EC has ever been diagnosed with COVID-19 and if so, the EC should be currently asymptomatic and at least ten (10) days must have passed since disease onset. EC's with signs and symptoms consistent with COVID-19 should not be allowed entry to a facility to perform essential caregiver functions. An EC who is unable to demonstrate proper use of infection control techniques should not be allowed to perform essential caregiver functions. Facility use of testing as part of the screening process must be based on current CMS, CDC, and FDA guidance and may be provided at the facility's expense.*
- The EC must wear all necessary personal protective equipment (PPE) while in the building and must wash or sanitize*

their hands regularly.

- The facility should ensure hand sanitizing stations and alcohol-based hand rubs are accessible.*
- EC's should inform the facility if they develop a fever or symptoms consistent with COVID-19 within fourteen (14) days of a visit to the resident.*
- The facility should maintain EC logs noting the names of EC's, who they visited, staff that assisted the during the visit, dates of visit, and contact information in the event of a subsequent COVID-19 outbreak among staff or residents.*
- The facility should work with the EC to establish a mutually agreeable schedule that addresses the facility obligations, including the numbers of EC's in the building at the same time, and is person-centered. This includes working with an EC by including scheduling during evening and weekends, to accommodate work or childcare barriers.*
- After attempts to mitigate concerns, the facility should restrict or revoke visitation if the EC fails to follow infection prevention and control requirements or other COVID-19-related rules of the facility.*
- A facility may stop Essential Caregiver visits if the facility has a resident test positive for COVID-19, or has a staff person that tests positive for COVID-19 if the staff person was in the facility in the ten (10) days prior to the positive test, until it has been fourteen (14) days since the last facility acquired COVID-19 positive case. Facility acquired cases include staff who test positive (if staff person was in the facility in the ten (10) days prior to the positive test) and residents who test positive while residing in the facility. Facility acquired does not include residents admitted to the facility with a known positive diagnosis or residents who test positive within fourteen (14) days of admission, as long as these residents have resided in a designated COVID-19 unit or have been quarantined since admission.*
- Essential Caregivers should maintain a social distance of at least six (6) feet with staff and other residents and limit movement in the facility.*
- The facility must allow evening and weekend visits that accommodate the EC, who may be limited by work or childcare barriers.*
- Facilities should direct the EC to provide care in the resident's room, or in facility-designated areas to limit movement in the facility.*
- The EC may take the resident outside for a walk during their time with the resident. Pushing the resident in a wheelchair is acceptable as long as the EC is wearing appropriate PPE and the resident is wearing a facemask, as tolerated.*
- While an EC visit is considered compassionate care, KDADS recommends that the EC not provide high-contact care activities during a resident's quarantine or isolation period.*
- Facilities should not restrict visitation without a reasonable clinical or safety cause. Prior to any restriction, the facility, EC, and resident should discuss any concerns.*

Window Visitation

Window Visitation is a great way to allow for loved ones to see each other while maintaining the up most vigilance for the spread of infection. Window visits should occur without consideration of community transmission level** or vaccination status. There are several factors that facilities and residents should consider when implementing window visitation.

- *Decide whether a window visit is the right fit for the resident*
 - Residents with dementia may not understand the rules of the visit or may forget. This type of visit may confuse or frustrate them.
 - Residents living on floors above ground level will need to use an alternate window. Facilities should determine where that will be possible.
- *Communication is Key*
 - Residents may get scared if people walk up to their window. Be sure the visitation plan is well communicated with residents, resident roommates and staff on duty.
 - Make a staffing plan that allows for staff availability for assistance so they can have residents dressed, ready, and at the window at the time of your visit.
 - Make a phone, walkie talkie, voice amplifier or other electronic communication device available if one is needed for the resident or their visitor to ensure clear communication can be achieved.
 - Ensure the visitor is well informed of when and where to go for their visit and any expectations they need to adhere to.
- *Implement safety measures*
 - If a resident's window will be open during the visit, the resident should stay 3 feet back from the window and should wear a cloth mask. The family member visiting the resident should sit 3 feet back from the window outside the building and wear a cloth face mask. If this cannot be met due to the facility's physical environment a total of 6 feet should be maintained between the resident and visitor but can be achieved through shifting the distance from either the resident to the window or visitor to the window footage to maintain a total of 6 feet. If the resident is fully vaccinated*, they can choose to have close contact (including touch) with their visitor while wearing a well-fitting face mask and performing hand-hygiene before and after. Regardless, visitors should physically distance from other residents and staff in the facility.
 - Staff can be creative about how they mark out the place families can sit outside the window.
 - All window visits should comply with social distancing requirements. Visitors must keep at least 6 feet away from people visiting other residents.

Outdoor Visitation

Outdoor visits pose a lower risk of transmission due to increased space and airflow and can be implemented without the consideration of the community transmission level**. Outdoor visitation should occur routinely for all residents that express an interest in having visitors even when the resident and visitor are not fully vaccinated* against COVID-19. Outside visits may be limited by weather considerations (e.g., inclement weather, excessively hot or cold temperatures, poor air quality), an individual resident's health status (e.g., medical condition(s), COVID-19 status, quarantine status), or a facility's outbreak status. Facilities should create accessible and safe outdoor spaces for visitation, such as in courtyards, patios, or parking lots, including the use of tents, if available. When conducting outdoor visitation, facilities should consider the following criteria:

- Adequate staff available to allow for help with outdoor transition of residents, and to assist with wiping down any visitation areas as necessary.
- Staff should be able to maintain visual observation but provide as much distance as necessary to allow for privacy of the visit conversation.
- Must have a system to ensure visitors are screened for signs and symptoms of COVID-19 at a screening location designated outside the building.
- Must have a system to ensure residents and visitors wear a mask or other face covering at all times, as tolerated. The facility should provide PPE as needed and provide signage or verbal reminders of appropriate use.
- Outdoor visitation spaces must be designed to be accessible without visitors having to walk through the facility.
- Outdoor visitation spaces must support social distancing of at least 6 feet between the visitor and resident. If the resident is fully vaccinated*, they can choose to have close contact (including touch) with their visitor while wearing a well-fitting face mask and performing hand-hygiene before and after. Regardless, visitors should physically distance from other residents, visitors and staff in the facility.
- Provide alcohol-based hand sanitizer to persons visiting residents and provide signage or verbal reminders of correct use.
- Maintain a detailed visitor log with the date and time of visitation, resident and staff encountered during visitation as well as contact information for the visitor.
- Visitors under age 12 years must be in the control of adults who bring them and must also comply with social distancing requirements.
- Pets must be under the control of the visitor bringing them in.

- Visitors must stay in designated visitation locations.
- Facilities may establish additional guidelines as needed to ensure the safety of visitations and their facility operations.

Indoor Visitation

See the current [CDC guidance at Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination](#) for information on indoor visitation.

Facilities should allow indoor visitation at all times and for all residents (regardless of vaccination status), except for a few circumstances when visitation should be limited due to a high risk of COVID-19 transmission (note: compassionate care visits should be permitted at all times).

These scenarios include limiting indoor visitation for:

- Unvaccinated residents*, if the nursing home's COVID-19 county positivity rate is >10% and <70% of residents in the facility are fully vaccinated*;
- Residents with confirmed COVID-19 infection, whether vaccinated* or unvaccinated* until they have met the [criteria to discontinue Transmission-Based Precautions](#); or;
- Residents in quarantine, whether vaccinated or unvaccinated, until they have met criteria for release from [quarantine](#).

Indoor visitation should be accommodated and supported based on the following guidelines

- Visitors should be able to adhere to the core principles and staff should provide monitoring for those who may have difficulty adhering to core principles, such as children;
- Facilities should consider limiting the number of visitors per resident at one time and limiting the total number of visitors in the facility at one time (based on the size of the building and physical space). Facilities should consider scheduling visits for a specified length of time to help ensure all residents are able to receive visitors; and
- Facilities should limit movement in the facility. For example, visitors should not walk around different halls of the facility. Rather, they should go directly to the resident's room or designated visitation area.
- If the patient/resident is in a single-person room, visitation could occur in their room.
- Visits for patients/residents who share a room should ideally not be conducted in the patient/resident's room.
 - If in-room visitation must occur (e.g., patient/resident is unable to leave the room), an unvaccinated roommate should not be present during the visit. If neither patient/resident is

able to leave the room, facilities should attempt to enable in-room visitation while maintaining [recommended infection prevention and control practices](#), including physical distancing and source control.

- If visitation is occurring in a designated area in the facility, facilities could consider scheduling visits so that multiple visits are not occurring simultaneously, to the extent possible. If simultaneous visits do occur, everyone in the designated area should wear source control and physical distancing should be maintained between different visitation groups regardless of vaccination status.
- Indoor visitation spaces must support social distancing of at least 6 feet between the visitor and resident. If the resident is fully vaccinated*, they can choose to have close contact (including touch) with their visitor while wearing a well-fitting face mask and performing hand-hygiene before and after. Regardless, visitors should physically distance from other residents, visitors and staff in the facility.
- Visitors should not bring food or drinks to share during the visitation but may consider being unopened items for the resident to enjoy without sharing during the visit or at a later time.
- Visitation locations will be equipped with sanitation supplies, readily available to visitors and residents.
- Facilities may establish additional guidelines as needed to ensure the safety of visitations and their facility operations.

CMS and CDC continue to recommend facilities, residents, and families adhere to the core principles of COVID-19 infection, including physical distancing (maintaining at least 6 feet between people). This continues to be the safest way to prevent the spread of COVID-19, particularly if either party has not been fully vaccinated. However, we acknowledge the toll that separation and isolation has taken. We also acknowledge that there is no substitute for physical contact, such as the warm embrace between a resident and their loved one. Therefore, if the resident is fully vaccinated*, they can choose to have close contact (including touch) with their visitor while wearing a well-fitting face mask and performing hand-hygiene before and after in accordance with the [CDC's Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination](#). Regardless, visitors should physically distance from other residents and staff in the facility.

~~**NOTE:** For situations where there is a roommate and the health status of the resident(s) prevents leaving the room, facilities should attempt to enable in-room visitation while adhering to the core principles of COVID-19 infection prevention.~~

Indoor Visitation during an Outbreak

An outbreak exists when a [new nursing home onset](#) of COVID-19 occurs (i.e., a new COVID-19 case among residents or staff). This guidance is intended to describe how visitation can still occur when there is an outbreak, but there is evidence that the transmission of COVID-19 is contained to a single area (e.g., unit) of the facility. To swiftly detect cases, we remind and recommend facilities to adhere to [CMS regulations and guidance for COVID-19 testing](#)***, including routine staff testing, testing of individuals with symptoms, and outbreak testing.

When a new case of COVID-19 among residents or staff is identified, a facility should immediately begin outbreak testing and suspend all visitation (except that required under federal disability rights law), until at least one round of facility-wide testing is completed. Visitation can resume based on the following criteria:

- *If the first round of outbreak testing reveals no additional COVID-19 cases in other areas (e.g., units) of the facility, then visitation can resume for residents in areas/units with no COVID-19 cases. However, the facility should suspend visitation on the affected unit until the facility meets the criteria to discontinue outbreak testing.*
 - For example, if the first round of outbreak testing reveals two more COVID-19 cases in the same unit as the original case, but not in other units, visitation can resume for residents in areas/units with no COVID-19 cases.
- *If the first round of outbreak testing reveals one or more additional COVID-19 cases in other areas/units of the facility (e.g., new cases in two or more units), then facilities should suspend visitation for all residents (vaccinated and unvaccinated), until the facility meets the criteria to discontinue outbreak testing.*

While the above scenarios describe how visitation can continue after one round of outbreak testing, facilities should continue all necessary rounds of outbreak testing. In other words, this guidance provides information on how visitation can occur during an outbreak but does not change any expectations for testing and adherence to infection prevention and control practices. If subsequent rounds of outbreak testing identify one or more additional COVID-19 cases in other areas/units of the facility, then facilities should suspend visitation for all residents (vaccinated and unvaccinated), until the facility meets the criteria to discontinue outbreak testing.

NOTE: In all cases, visitors should be notified about the potential for COVID-19 exposure in the facility (e.g., appropriate signage regarding current outbreaks), and adhere to the core principles of COVID-19 infection prevention, including effective hand hygiene and use of face-coverings. We also note that compassionate care visits and visits required under federal disability rights law should be allowed at all times, for any resident (vaccinated or unvaccinated) regardless of the above scenarios. Lastly, facilities should continue to consult with their state or local health departments when an outbreak is identified to ensure adherence to infection control precautions, and for recommendations to reduce the risk of COVID-19 transmission.

Communal Activities and Dining

While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur. Book clubs, crafts, movies, exercise, and bingo are all activities that can be facilitated with alterations to adhere to the guidelines for preventing transmission. The CDC has provided additional guidance on activities and dining based on resident vaccination status.

For example, residents who are fully vaccinated may dine and participate in activities without face coverings or social distancing if all participating residents are fully vaccinated. If unvaccinated residents are present during communal dining or activities, then all residents should use face coverings when not eating and unvaccinated residents should physically distance from others. See the [CDC guidance Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination](#) for information on communal dining and activities.

- *Who Should not participate in communal activities?*
 - Vaccinated and unvaccinated patients/residents with SARS-CoV-2 infection, or in isolation because of suspected COVID-19, until they have met [criteria to discontinue Transmission-Based Precautions](#).
 - Vaccinated and unvaccinated patients/residents in [quarantine](#) until they have met criteria for release from quarantine.
- *What infection prevention and control practices are recommended when planning for and allowing communal dining and activities?*
 - Determining the vaccination status of patients/residents/HCP at the time of the activity might be challenging and might be subject to local regulations. When determining vaccination status, the privacy of the patient/resident/HCP should be maintained (e.g., not asked in front of other patients/residents/HCP). For example, when planning for group activities or communal dining, facilities might consider having patients/residents sign up in advance so their vaccination status can be confirmed, and seating assigned. If vaccination status cannot be determined, the safest practice is for all participants to follow all recommended infection prevention and control practices including maintaining physical distancing and wearing source control.

Patients/Residents

Facilities should have a system in place to be aware of each resident's needs, including the need for infection control interventions to protect a resident from a communicable disease, these needs should be met through a person-centered approach. However, fully vaccinated residents may choose to have close contact with their visitors regardless of the visitor's vaccination status.

- *Group activities:*
 - If all patients/residents participating in the activity are fully vaccinated, then they may choose to have close contact and to not wear source control during the activity.
 - If unvaccinated patients/residents are present, then all participants in the group activity should wear source control and unvaccinated patients/residents should physically distance from others.
- *Communal dining:*
 - Fully vaccinated patients/residents can participate in communal dining without use of source control or physical distancing.

- If unvaccinated patients/residents are dining in a communal area (e.g., dining room) all patients/residents should use source control when not eating and unvaccinated patients/residents should continue to remain at least 6 feet from others.
- Patients/residents taking social excursions outside the facility should be educated about potential risks of public settings, particularly if they have not been fully vaccinated, and reminded to avoid crowds and poorly ventilated spaces. They should be encouraged and assisted with adherence to all recommended infection prevention and control measures, including source control, physical distancing, and hand hygiene. If they are visiting friends or family in their homes, they should follow the source control and physical distancing recommendations for visiting with others in private settings as described in the [Interim Public Health Recommendations for Fully Vaccinated People](#).

Healthcare Personnel

In general, fully vaccinated HCP should continue to wear source control while at work. However, fully vaccinated HCP could dine and socialize together in break rooms and conduct in-person meetings without source control or physical distancing. If unvaccinated HCP are present, everyone should wear source control and unvaccinated HCP should physically distance from others.

Recommendation for use of personal protective equipment by HCP remains unchanged and HCP should adhere to the following the [Interim Infection Prevention and control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic](#) while providing patient care.

If the HCP(s) is not providing patient care (i.e. eating assistance) fully vaccinated residents and HCP could eat their meals together following the communal dining section(s) of both CMS and KDADS visitation guidance.

Visitor Testing and Vaccination

While not required, we encourage facilities in medium- or high-positivity counties to offer testing to visitors, if feasible. If so, facilities should prioritize visitors that visit regularly (e.g., weekly), although any visitor can be tested. Facilities may also encourage visitors to be tested on their own prior to coming to the facility (e.g., within 2–3 days). Similarly, we encourage visitors to become vaccinated when they have the opportunity. While visitor testing and vaccination can help prevent the spread of COVID-19, visitors should not be required to be tested or vaccinated (or show proof of such) as a condition of visitation. This also applies to representatives of the Office of the State Long-Term Care Ombudsman and protection and advocacy systems, as described below. Visitors shall be given the opportunity to disclose their vaccination status to determine if the visitor may have close contact (including touch) and not wear source control while alone in a resident's room or the designated visitation room, however the facility may not require visitors to disclose their vaccination status or to show proof of vaccination. Visitors that decline to disclose their vaccination status should adhere to the infection control principles of COVID-19 infection prevention for unvaccinated persons.

NOTE: Visitors who choose to disclose their vaccination status are not required to show proof of vaccination for status to be valid.

Access to the Long-Term Care Ombudsman

Regulations at 42 CFR § 483.10(f)(4)(i)(C) require that a Medicare and Medicaid- certified nursing home provide representatives of the Office of the State Long-Term Care Ombudsman with immediate access to any resident. K.A.R. 26-39-102(g)(4) also has this same requirement that all Adult Care Homes must follow. During the public health emergency, in-person access may be limited due to infection control concerns and/or transmission of COVID-19, however, in-person access may not be limited without reasonable cause. Representatives of the Office of the Ombudsman should adhere to the core principles of COVID-19 infection prevention as described above. If in-person access is deemed inadvisable (e.g., the Ombudsman has signs or symptoms of COVID-19), facilities must, at a minimum, facilitate alternative resident communication with the ombudsman, such as by phone or through use of other technology. Nursing homes are also required under 42 CFR § 483.10(h)(3)(ii) to allow the Ombudsman to examine the resident's medical, social, and administrative records as otherwise authorized by State law as are all Adult Care Homes per K.S.A. 39-1406.

Federal Disability Rights Laws and Protection & Advocacy (P&A) Programs

Section 483.10(f)(4)(i)(E) and (F) requires the facility to allow immediate access to a resident by any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act), and of the agency responsible for the protection and advocacy system for individuals with a mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000). P&A programs authorized under the DD Act protect the rights of individuals with developmental and other disabilities and are authorized to “investigate incidents of abuse and neglect of individuals with developmental disabilities if the incidents are reported to the system or if there is probable cause to believe the incidents occurred.” 42

U.S.C. § 15043(a)(2)(B). Under its federal authorities, representatives of P&A programs are permitted access to all facility residents, which includes “the opportunity to meet and communicate privately with such individuals regularly, both formally and informally, by telephone, mail and in person.” 42 CFR § 51.42(c); 45 CFR § 1326.27.

Additionally, each facility must comply with federal disability rights laws such as Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA). For example, if a resident requires assistance to ensure effective communication (e.g., a qualified interpreter or someone to facilitate communication) and the assistance is not available by onsite staff or effective communication cannot be provided without such entry (e.g., video remote interpreting), the facility must allow the individual entry into the nursing home to interpret or facilitate, with some exceptions. This would not preclude nursing homes from imposing legitimate safety measures that are necessary for safe operations, such as requiring such individuals to adhere to the core principles of COVID-19 infection prevention.

We believe the guidance above represents reasonable ways an adult care home can facilitate in-person visitation. Except for on-going use of virtual visits, facilities may still restrict visitation due to the COVID-19 county positivity rate, the facility's COVID-19 status, a resident's COVID-19 status, visitor symptoms, lack of adherence to proper infection control practices, or other relevant factor related to the COVID-19 Public Health Emergency (PHE.) However, facilities may not restrict visitation without a reasonable clinical or safety cause, consistent with 26-39-103(m)***. Failure to facilitate visitation, without adequate reason related to clinical necessity or resident safety, would constitute a potential violation of 26-39-103(m)

and the facility would be subject to citation and enforcement actions.

Residents who are on transmission-based precautions for COVID-19 should only receive visits that are virtual, through windows, or in-person for compassionate care situations, with adherence to transmission-based precautions. However, this restriction should be lifted once transmission-based precautions are no longer required per CDC guidelines, and other visits may be conducted as described above.

If facilities have questions regarding the KDADS visitation guidance, contact KDADS.reopening@ks.gov.

****Fully vaccinated** refers to a person who is ≥ 2 weeks following receipt of the second dose in a 2-dose series, or ≥ 2 weeks following receipt of one dose of a single-dose vaccine, per the [CDC's Public Health Recommendations for Vaccinated Persons](#).*

****Unvaccinated** refers to a person who does not fit the definition of "fully vaccinated," including people whose vaccination status is not known, for the purposes of this guidance.*

***Facilities should use their community transmission level as the trigger for staff testing frequency. Reports of COVID-19 level of community transmission are available on the CDC COVID-19 Integrated County View site: <https://covid.cdc.gov/covid-data-tracker/#county-view>. Please see the COVID-19 Testing section on the CMS COVID-19 Nursing Home Data webpage: <https://data.cms.gov/covid-19/covid-19-nursing-home-data> for information on how to obtain current and historic levels of community transmission on the CDC website. Table 2: Routine Testing Intervals by County COVID-19 Level of Community Transmission. Please note that Federally Certified Nursing facilities are also still subject to [QSO Memo 20-39-NH](#).*

****Federally Certified Nursing facilities are also subject to compliance of 42 CFR 483.10(f)(4) and 42 CFR 483.80(h).*